

Lessons Learned from Missouri's Health Home Implementation

Introduction

The 2010 Patient Protection and Affordable Care Act (ACA) established a “health home” option under Medicaid to serve enrollees with chronic conditions by building a person-centered system of care that achieves improved outcomes for beneficiaries and better services and value for State Medicaid programs. The health home service delivery model is intended to provide a cost-effective, longitudinal “home” to facilitate access to an inter-disciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions. Health homes are designed to improve the health care delivery system for individuals with chronic conditions by employing a “whole-person” approach – caring not just for an individual’s physical condition, but providing linkages to long-term community care services and supports, social services, and family services. The health home service delivery model is expected to result in lower rates of emergency room use, reduction in hospital admissions and re-admissions, reduction in health care costs, less reliance on long-term care facilities, and improved experience of care and quality of care outcomes for the individual. The guidance from the Centers for Medicare and Medicaid Services (CMS) regarding the Medicaid health home option indicates that health homes do not need to provide the full array of required services themselves, but must ensure such services are available and coordinated. This gives a behavioral health agency several options for how to structure the behavioral health home, depending on its resources (e.g., physical facilities, number of consumers served, available workforce, financing options, community partners). The first SPA that was approved by CMS serves eligible enrollees using CMHCs in Missouri. It was approved by CMS on October 20, 2011, and creates health homes in community mental health centers (CMHCs) for Medicaid enrollees with behavioral health conditions. The second was approved on December 22, 2011, and creates health homes in primary care clinics (PCCs) for Medicaid enrollees with chronic physical conditions. Both SPAs were effective as of January 1, 2012. Implementing and

operating health homes requires that Community Mental Health Centers (CMHCs) learn many new tasks, skills, and work processes. This paper presents many of these required new learning that occurred in Missouri and is presented in the hope that other states will be able to implement their health homes more rapidly and effectively without having to repeat our mistakes.

Dual Eligibles

A State may elect in its State plan to provide health home services to individuals eligible to receive health home services based on all the chronic conditions listed in the statute, or provide health home services to individuals with particular chronic conditions. While all individuals served must meet the minimum statutory criteria, States may elect to target the population to individuals with higher numbers or severity of chronic or mental health conditions. The population must include all categorically needy individuals who meet the State's criteria. States cannot exclude from health home services:

- 1) Dual eligible beneficiaries.
- 2) Managed care, fee for service, or waiver enrolled beneficiaries as a category
- 3) Specific age ranges of beneficiaries

Statewide about 35% of CMHC Healthcare Home (CMHC-HH) enrollees are dually eligible for Medicare and Medicaid (range: 22% to 64% across CMHC-HHs). This is significant because the CMHC-HH Care Management Reports and hospital admissions notification system are based on Medicaid paid claims and Medicaid authorizations, respectively. (See "Care Management", below.) Consequently, the Care Management Reports do not reflect services or medications purchased by Medicare, and the daily hospital admission notifications do not capture admissions paid by Medicare. Therefore, the higher the percentage of dual eligibles enrolled in a Healthcare Home, the greater the likelihood the CMHC-HH will have less than a complete picture of the health status and service utilization of enrollees, spend time tracking down "false positives" (i.e. cases where it appears an individual has not received a needed service or medication when

Medicare has, in fact, paid for the service or medication), and will not be notified of a significant number of hospital admissions.

Coordination with Managed Care Organizations and Long-Term Services and Supports

Managed Care Organizations (MCOs) did not play much of a role in patient enrollment and care coordination for either the Primary Care Health Home (PC-HH) or CMHC-HH program. The proportion of enrolled health home participants who are also a part of an MCO is small, and most are children. This reflects the makeup of the managed care population in the state and the distribution of the eligible chronic disease criteria in the Medicaid population. When designing and applying for the two Missouri health home programs and in conversations with CMS, the state leadership established that the services provided by the health home case managers would be unique and non-duplicative of services provided by the MCOs. Missouri's Medicaid Program locally known as MO Health Net explained that the roles and responsibilities of the managed care plans in relation to the health home programs are detailed in the managed care contracts with MO HealthNet. The contract language indicates that MCOs, through their case managers, should work with the health homes to coordinate the care of mutually shared members.

Additionally, the MCOs are required to submit at least one encounter data file per month to MO HealthNet and the encounters must be submitted within 30 days of the date that the claim is paid. However, despite the agreed upon roles and responsibilities outlined in their contracts there is little to no interaction with MCOs or MCO case managers. Very few HH enrollees are MCO members and that, for those who are, the HHs only interactions with the MCO are to obtain authorizations or get help with filling out forms for the MCO.

Another similar challenge is the need for improved coordination with and integration of Long-Term Services and Support (LTSS). Nurse care managers and care coordinators should be working with nursing homes in the same way they work with hospitals to follow up after patients have been discharged. However, they noted that there have been challenges in coordinating with nursing homes. Individuals enrolled in Home and Community-Based Services (HCBS) may also be enrolled in one of the Missouri health home programs. For these individuals, all care coordination activities are managed by the health home community support worker or care coordinator, but the HCBS program care coordinators help the enrollee coordinate all community

support services. It is unclear how much communication occurs between these two programs. MO HealthNet is working with the HCBS program to further develop that process.

Children in the Health Home Programs

Section 2703 of the Affordable Care Act required that eligible children and adults be included in health home programs. Based on the required chronic disease criteria, children make up only a small portion of the enrolled population in both of Missouri's health home programs. The current health home model captures a smaller proportion of children for a variety of reasons. The health home program criteria target children with more than one chronic condition, a serious persistent mental illness, or other behavioral health condition with a chronic condition. Fewer children meet these eligibility criteria as chronic conditions (other than asthma, pediatric obesity, and developmental disability) are less prevalent in the pediatric population. The majority of children's health care services revolve around preventive care as opposed to management of chronic diseases. A key goal of the health home program is to reduce the costs of care associated with chronic disease and that children are generally not utilizing those related services at the same rate as adults. All of these factors contribute to the health home programs being weighted toward the care of adults as compared to children.

CMS Prohibition of Capitation Payment Methodology

The CMS requirement to only pay for a documented service to a specific enrollee during each paid month instead of a true per capita payment for an enrolled beneficiary to their assigned health home is a significant challenge and administrative burden.

Nurse Care Managers

Two decisions that proved quite successful were requiring that the nurse care managers be new hires as opposed to assigning additional duties to existing staff and requiring that the nurse care managers hire the primary care nurses, not psychiatric nurses. We have found that unless a nurse care manager is spending at least half their time in the nurse care manager role the new nurse care management duties tend to get short shrift compared to traditional CMHC nursing duties. Since CMHC already have clinical staff with extensive experience in the area of mental health it is important to add staff that have specialized experience in general medical care if the health home is to effectively undertake managing all the medical needs of the persons enrolled. Although there was concern that CMHCs would not be able to hire an adequate numbers of nurses to fill the projected number of Nurse Care Managers needed, when the CMHC Healthcare

Home opened in January, only six CMHCs did not fully meet the Nurse Care Manager staffing standard. By February only three of these sites did not fully meet the staffing standard, and by April, only one site continued to have difficulty meeting the standard. Most sites exceeded the Nurse Care Manager staffing standard every month.

A few CMHCs experienced some turnover in their Nurse Care Manager positions, resulting in falling below the standard for a short period until a replacement could be hired; but turnover has been less than might be expected given the nursing shortage and competition for nursing staff.

Unless they have done care management before the nurses hired to be care managers will feel responsible for getting every aspect of care correct for every patient in a very short period of time. This is simply not feasible and will lead to burnout and staff turnover. One helpful analogy is to explain population management in your agency is like public health nursing where the clinic population is the community receiving the public health service. Public health nurses see themselves as successful if they are able to increase the percentage of people in the community they serve who receive only a few key selected interventions (immunization, HIV screening, etc.). Similarly care managers in CMHC based health homes are successful if they decrease the percentage of patients in the health home who have a few selected care gaps.

Primary Care Physician Consultants

The Primary Care Physician Consultant position was created to introduce a primary care perspective into organizations focused on behavioral health. In addition it would not be appropriate to have mental health care clinicians and primary care nurses attempting to manage and coordinate the general medical needs of the health home enrollees without having primary care physician expertise available when needed. The Primary Care Physician Consultant:

- Assists the CMHC Healthcare Home in establishing priorities for disease management and improving health status,
- Helps educate community support specialists, case managers, and other clinical staff in the nature, course, and treatment of diabetes, COPD/asthma, cardiovascular disease, metabolic syndrome, and other prevalent chronic conditions,
- Participates in case reviews of individual CMHC Healthcare Home consumers, and
- Assists the CMHC in developing collaborative relationships with treating PCPs, as well as other healthcare professionals and facilities serving CMHC Healthcare Home enrollees.

The consultant does not provide any direct care to the enrollee, unless they happen to be the enrollee's primary care physician outside of the CMHC. The physician consultant's role is to assist the CMHCs in strengthening their primary care coordination activities. Consultants do this by helping nurse care managers develop care plans for enrollees and by implementing quality improvement or education initiatives within the CMHCs. Consultants also work to raise awareness of the CMHC health home among other health care providers and hospitals in the CMHC catchment area in order

to promote care coordination of enrollees who receive primary care services outside the CMHC, who are seen in the ED or are hospitalized. PCP consultants also provide patient and staff education about medical conditions. For example an “Ask the Doc,” session for patients allowed them to better understand their diagnosis and medication regimens. Brown bag lunches with staff help educated them about chronic health conditions so they can better explain and track this in their patients. Lastly, the PCP consultant provides a unique opportunity to partner with the in-house psychiatric team to review patients with chronic conditions, consult on urgent issues and retrain them in the current treatment of common conditions. PCP consultants write letters to their outside specialist or primary care physician with suggestions for altering their medication or care plan. These letters are not always well-received or maybe ignored by outside physicians while at other times they were appreciated, thus highlighting the PCP consultants’ important role in fostering positive relationships with these providers.

CMHC Healthcare Homes can choose to utilize an Advanced Practice Nurse to help meet the Primary Care Physician Consultation staffing requirement. But a physician must provide at least one-half the required Primary Care Physician Consultant hours, with the Advanced Practice Nurse providing double the number of hours the physician would have provided.¹

Engaging Primary Care Physicians (PCPs) in this new role proved to be challenging for several CMHCs. Seven CMHCs were unable to secure the consultation services of a PCP for the month of January, and difficulty in understanding how to best utilize Primary Care Physician Consultants resulted in under utilization of their time. However, CMHC Healthcare Homes have dramatically improved in meeting the Primary Care Physician Consultant staffing requirement. Over the course of a year, CMHC Healthcare Homes are expected to meet at least 85% of the staffing standard. By June, the six CMHCs that used the combination of a PCP and an Advanced Practice Nurse were all exceeding the Primary Care Physician Consultant staffing expectations.

CMHC-HH Administration

Another particularly successful decision was requiring that each CMHC-HH have a at least half time Health Home Director to serve as the administrative lead. The role of the health home director is to oversee the practice transformation and training of the health home team. Implementation of the health home care delivery model requires substantial reworking of traditional CMHC work processes it also requires entering into formal relationships with community hospitals in primary care practices. The health home director provides a single point of accountability for both the CMHC-HH and the state team responsible for implementing the health home program. Seven of the larger CMHC Healthcare Homes did not fully meet the

¹ For example, if a total of 500 hours were required, a physician would have to provide at least 250 hours, and an Advanced Practice Nurse would be required to provide 500 hours in order to substitute for the additional 250 physician hours required.

administrative staffing expectations during the first six months. All of these CMHCs had a full time Healthcare Home Director and at least one clerical staff. The issue these larger Healthcare Homes faced was how best to utilize the additional administrative support available to them as part of their PMPM Healthcare Home reimbursement. These organizations were given time to have some experience with operating their Healthcare Homes so that they could better assess their administrative needs. Each must submit an administrative plan for approval by the Department, and each is expected to meet at least 85% of the administrative staffing standard over the course of the year.

Metabolic Screening

Because of the significant potential for developing Metabolic Syndrome, CMHC-HHs are required to conduct an annual metabolic screening on all individuals receiving psychotropic medications. CMHC-HHs report metabolic screening values to a statewide data base. This information is compared with Medicaid claims data to generate components of the Disease Management Reports (see below).

Metabolic screening is usually completed at the time of the individual's annual treatment plan update, though screening may be done more frequently as appropriate. Because annual treatment plan updates are typically spread unevenly throughout the year, it would not be surprising to find that fewer than 50% of the individuals enrolled in the CMHC Healthcare Homes had updated metabolic syndrome screens during the first six months. However, Metabolic Screening data was updated for only about one-third of the CMHC-HH enrollees as of June, 2012. It took until June, 2013 (18 months) to achieve a 70% percentage of CMHC-HH enrollees with updated metabolic syndrome values. Creating a database that accurately merged clinical values coming in from 27 different organizations was particularly challenging and significantly more time and resource than was anticipated initially. We were not successful until we implemented a rapid cycle improvement process to work through the data transmission, aggregation, and reporting problems one at a time.

Training, Technical Assistance, and System Transformation

Training and technical assistance have been, and will continue to be, critical to the successful implementation of the CMHC Healthcare Home initiative.

In the summer of 2011, each CMHC was required to introduce the health home initiative by presenting "Paving the Way for CMHC Healthcare Homes", a PowerPoint overview describing the reasons for, and key elements of, the initiative, to all of their staff. In the fall of 2011, the leadership of each CMHC attended training on HCH implementation, and all new HCH staff attended two days of "Healthcare Home 101" training that included an introduction in how to use the Care Management reports and tools.

Beginning in July 2011 through June, 2012, the consulting group MTM Services worked with each CMHC to improve access to care using strategies such as collaborative documentation, same day access models, no show models, centralized scheduling, utilization review and utilization management, and staff productivity/performance standards.

In March, the Care Management Reports that CMHCs receive migrated to a new web-based system developed by the data analytics company, CMT, called 'ProAct'. Following an initial March webinar in how to use ProAct, CMT has offered bi-weekly conference calls designed to both provide general training in utilizing ProAct and to answer specific questions and/or problems have in utilizing ProAct.

A Physician's Institute held in June provided the first opportunity for Primary Care Physician Consultants to convene on a statewide basis for training and networking.

Nurse Care Managers and other clinical staff have had opportunities to participate in training regarding the nature, course and treatment of chronic diseases, motivational interviewing, and TEAMcare.

All CMHCs are now in a major initiative to train community support specialists and case managers in Wellness Coaching.

CMHCs have appropriately participated in the monthly CMHC-HH Director webinars, required administrative and team training, as well as taking advantage of the variety of optional training opportunities offered.

DMH and Coalition of Community Mental Health Centers staff has conducted a number of on-site reviews at CMHC-HH to assess the progress of implementation, clarify policies and procedures, and provide technical assistance. Site visits will continue to be conducted as part of the process of assuring that CMHCs continue development of fundamental health home functionality.

Early in 2012, Missouri was approached by the Council on Accreditation of Rehabilitation Facilities (CARF) and asked to work with them on the development of standards for Behavioral Health Homes. The new standards were published in the summer of 2012.

Most CMHCs in Missouri already have CARF Accreditation for many of their programs. Those CMHCs that already have CARF accreditation for some of their programs must be accredited by CARF as Behavioral Health Homes by January, 2014. The small number of CMHCs who do not currently have, and have not already been preparing for, CARF accreditation will have until April, 2014 to receive CARF accreditation of their Healthcare Homes.

Having weekly State level internal Management meetings has been essential to keep up with the multiple and rapidly evolving issues that must be discussed and decided in the implementation

process. It is been very useful the state implementation team to take a customer responsive approach to the CMHC-HH staff. The majority of actions taken by the state level internal management team have been a result of reports of difficulty or request for help from the CMHC-HHs. The state level internal management team is staffed by senior managers with long experience in the Missouri public health and Medicaid systems. Their pre-existing knowledge of the Missouri environment and relationships with senior leadership at the CMHCs has been a great advantage during the implementation process. In the first year of implementation Missouri also utilized a Learning Collaborative that was delivered by an out-of-state group of experts who provided a predetermined, preset curriculum. This learning collaborative was not nearly as helpful as other implementation activities. In hindsight it would have been much more successful if the curriculum had been developed on an ad hoc basis in real time in response to what the CMHC-HHs were reporting that they needed help with and if the consulting experts delivering learning collaborative had regularly participated in the periodic conference calls with the internal state management team and helpful directors described below.

Biweekly to Monthly CMHC-HH Directors and Nurse Care Manager calls/webinars have been used to manage implementation issues, and CMHC-HH team members have been able to participate in monthly calls designed to improve their ability to use the Care Management reports and tools. The calls and Webinars have been essential for providing information and guidance about the rapidly changing requirements and processes involved in CMHC-HH implementation. The agenda of these conference calls is driven primarily by the topics where assistance was requested are needed as reported by the practice coaches or from telephone and e-mail inquiries from the CMHC-HHs to the internal state implementation team.

As the result of a grant from the Missouri Foundation for Health, beginning in November, 2012 CMHC Healthcare Homes will be assigned Practice Coaches to assist them in preparing to meet the CARF Behavioral Health Home standards, and to assist in continuing to develop health home functionality. Site visits to CMHC-HHs and adding Practice Coaches who have weekly-monthly calls with each CMHC-HH individually has been a great help in accelerating implementation of the health home care delivery model. The practice coaches review the care management benchmark reports to identify areas where that individual CMHC-HH is struggling and then strategize with the CMHC-HH leadership how to change their work processes and procedures to overcome the problematic area. Practice coaches also review CMHC-HH documentation inpatient charts and on treatment plans. They have been very helpful in helping the CMHC-HHs understand the new documentation expectations, particularly in the area of addressing general medical needs as part of the traditional mental health treatment plan. Practice coaching has been so successful that we intend amend our CMHC-HH rate to cover the cost of providing practice coaching ongoing.

As they continue to mature as health homes over the coming months, CMHCs face a number of challenges in the ways they think about their work and in their actual practice.

Relating to Outside Providers

We have noted that most CMHC-HH enrollees have a Primary Care Physician. However the challenge is to assure that individuals don't just have a PCP, but rather that they actually use them, and have an effective clinical relationship with them. Also it is not enough for the PCP to be aware that their patient is enrolled in a CMHC-HH. The CMHC-HH should have an effective working relationship with the PCP, sharing appropriate clinical information on a regular basis.

We have already acknowledged some of the challenges involved in following up on hospitalizations. Developing the multiple relationships need to effective work with a variety of hospitals will be a continuing challenge.

Helping staff to learn more about chronic diseases, and health and wellness, and how to assist individuals in managing their chronic diseases and improve their health status will be an ongoing challenge.

Information Overload

Perhaps most challenging will be the learning that will come as a result of the variety of care management reports now available to the CMHC-HHs.

Care management reports provide more information about the individuals they serve than they have ever had before. For the first time, they provide an opportunity to focus on proactively managing the health status of populations (all individuals with diabetes or asthma, or who are significantly overweight), in addition to responding to the needs of individual consumers.

The volume of information is almost overwhelming. Prioritizing becomes critical; as do learning how to sift through the information and identify what is most important to focus on, as well as how to routinely use the available data in making clinical decisions and monitoring progress.

In the coming months, we will be trying to understand what works best, and looking for new ways to facilitate the new learning that is required, as well as assessing our progress toward maturity as a Healthcare Home system.

Improving the Quality of Psychiatric Prescribing

Surprisingly the disease management/quality indicators related to psychiatric prescribing practices have been the hardest to generate improvement in. CMHC-HH staff report that they have not been able to meaningfully engage their agencies psychiatrists and a dialogue about opportunities to improve the quality of psychiatric prescribing practices. We are planning another statewide CMHC-HH physician summit in the fall of 2013 that will focus on the role of

the psychiatrist in the CMHC-HH with a particular focus on mutual roles and responsibilities with respect to CMHC-HH nurse care managers and primary care physician consultants.

Overall Conclusions

We have noted a general pattern of smaller agencies being able to implement and execute the new CMHC-HH care delivery model more rapidly and effectively than larger organizations.

Organizations that treat the new CMHC-HH care delivery model as a separate team or separate freestanding new service do not do nearly as well as organizations that treat the CMHC-HH as an overall transformation of how they deliver care in general.

The implementation has proceeded in three fairly distinct phases or areas of emphasis:

- 1) Hiring and training the new staff required for both the individual CMHC-HHs and the statewide internal management team.
- 2) Developing the aggregate databases and reporting capacity that constitutes our statewide patient registry. Including actual individual clinical values in the statewide central database was much more challenging than anticipated.
- 3) Assisting CMHC-HH staff in understanding how to use the data analytics tools provided and how to change multiple long standing agency work processes in order to make their care data-driven and population-based as is required for successful CMHC-HH operation.

The implementation has taken more effort and resources than anticipated by either the CMHC-HHs or the state internal management team.

The implementation has been more rewarding in terms of improving the motivation and morale of the people involved than anticipated by either the CMHC-HHs or the state internal management team.

Initial rough estimates of outcomes achieved are showing decreases in hospitalization rates, improvements in clinical quality indicators, and an overall savings of approximately \$80MPM.